



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

IDRIS GHARBAOUI MD  
7401 SOUTH MAIN STREET  
HOUSTON TX 77030-4509

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-4412-02

#### **MFDR Date Received**

AUGUST 1, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Claim is being paid incorrectly at the non facility rate."

**Amount in Dispute:** \$193.78

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "the carrier challenges whether the charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011	CPT Code 26442-59-RT	\$193.78	\$0.00

### **FINDINGS AND DECISION**

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

#### **Explanation of benefits**

- 59-Processed based on multiple or concurrent procedure rules.

## **Issues**

1. Is the requestor entitled to additional reimbursement for CPT code 26442-59-RT?

## **Findings**

1. According to the submitted explanation of benefits the insurance carrier denied reimbursement for CPT code 26442-59-RT based upon reason code "59".

CPT code 26422 is defined as "Tenolysis, flexor tendon; palm AND finger, each tendon."

The requestor appended modifier 59 to CPT code 26422.

Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the Operative report indicates that the claimant underwent "Tenor-arthrolysis, flexor digitorum superficialis, flexor digitorum profundus, right long finger; and Release range of ligament, proximal interphalangeal joint, right long finger." The Operative report supports the billed service.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 68.47.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77030, which is located in Harris County.

The Medicare participating amount for code 26442 in Harris County is \$945.43.

CPT code 6442 is subject to multiple procedure discounting.

Using the above formula, the MAR is \$952.63.

The respondent paid \$758.82. The requestor is due the difference between the MAR and amount paid that equals \$193.81. The requestor is seeking a lesser amount of \$193.78; this amount is recommended in additional reimbursement.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$193.78.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$193.78 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	7/26/2013 Date
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### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**